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Health Care Reform Terms and Concepts

Michigan's health care reform discussion, triggered by HB 5345's (as introduced) proposal to pool all public employees health benefits, is complicated by the many terms and concepts that are bandied about in discussions. This Brief explains some of these commonly used terms and concepts, but does not touch on all of the nuance and subtlety that shade them. There will always be something to add to the starting point offered here.

First, it is important to start with the basic premise of insurance – it is a means to manage risk or avert the consequences of low probability events. Health insurance differs from other types of insurance in that access and cost are highly dependent on whether you are an individual or a group seeking insurance and how large of a group you are in. The size of the group or pool has an impact on health insurance costs in two different ways:

Risk Pool refers to the sharing of risk across all members of the group. The risk of incurring health claims, which reflects group member use of health care services, will be driven by unpredictable events (e.g., accidents, acute care needs, or the onset of disease) and predictable events (e.g., age or gender appropriate preventive care, treating existing chronic diseases). All groups will have a number of minimal and heavy users of health care. The larger the group the more likely the minimal users will be significantly larger in number than the heavy users, thereby spreading the risk and cost of care in a large pool.

Purchasing Pool refers to the economies of scale and purchasing leverage that can be exercised by groups, particularly large groups. Administrative fees charged per member are often significantly lower for large groups than small groups. Small groups that merge with other groups to form large groups can see reductions in administrative fees. Bulk purchasing of services, such as pharmaceuticals, can also be used to leverage better purchase prices for larger groups.

The remainder of this Brief presents terms loosely organized under the headings of *general health benefits* and *pharmacy benefits*. These headings represent areas of emphasis for the terms and concepts rather than absolute categories with no overlap.

General Health Benefit Terms

Administrative Services Fees are the day-to-day costs of implementing health benefits charged by entities to support health plans, such as, processing claims, adjudicating claims, handling enrollment, collecting premiums, etc. Fees, frequently charged on a per member per month basis, are usually smaller for large groups and higher for small groups. These fees, also known as *ASO* (administrative services only) or *ASA* (administrative services agreement), are transparent to self-insured employers who contract for administrative services, but may be rolled into the premiums paid to insurers. Other fees that are not included in administrative fees may also be charged, such as, access fees for provider networks; fees for brokers, consultants, and agents; retention and reallocation fees; and administrative burden assumed by providers when submitting patient claims.

Actuarial Analysis or Study is a mathematical study of uncertainty, risk, and the resulting financial impact. Such a study can look at the actual claims experience of a group or the likely experience of the group based on their age, gender, and health status to project how that group will use health benefits in the future. That analysis will be used to set the price for health benefit coverage.

Chronic Care (Disease) Management refers to the proactive steps taken for clinical intervention, therapeutic oversight, and education that are necessary to motivate patients with chronic disease to sustain the therapeutic regimens and lifestyle changes that will enhance their health and quality of life.

Clinical Advocates, such as Best Doctors refers to a program which provides in-depth expert clinical information to a patient—at their request—and to the patient's physician to help ensure that patients are diagnosed properly and receive the correct medical care. Employers generally contract with a clinical advocate program upon the expectation that when employees receive correct medical care, covered medical costs are reduced. The term clinical advocates is also sometimes used to refer to patient advocates who are distinctly different from clinical advocates. Patient advocates are generally not clinical experts. They provide information and support to patients to help them navigate the healthcare system and make informed healthcare decisions.

Clinically Sensitive Cost Sharing refers to establishing copay rates that differ by type of service or by patient group in order to recognize the clinical benefits that can be achieved. For instance, clinically sensitive cost sharing would mean that copays are higher for low value medical services than they are for high value medical services. Additionally, copays for certain medical services for certain patient groups, such as for diabetics, would be different than for other patient groups. Clinically sensitive co pays are a characteristic of "*Value-Based Insurance Design.*"

Co-insurance typically refers to a percentage of the cost that a member is responsible for when using a particular benefit. For example, a member might be responsible for 100% of the benefit cost until the deductible is reached and then assumes a co-insurance of 20% after the deductible is reached. Different co-insurance rates may apply to in-network and out-of-network benefits. Larger coinsurance rates are typically imposed on out-of-network benefits.

Community Rating, in its purest form, bases the health insurance premiums on member enrollment status (e.g., individual, family) and precludes the insurer from considering the member's health status in setting the premium price. Modified or adjusted community rating will allow the insurer to consider geography (e.g., residence), age, or gender in setting the premium price but not health status.

Consumer Driven (Directed) Health Plans is a term typically applied to the combination of consumer expenditures and high deductible health plans (HDHP). Consumer expenditures are the first dollars spent and may come from a health reimbursement arrangement, health savings account, or out-of-pocket. Health care costs are shared by the HDHP once consumers have spent the deductible limit for the plan.

Coordination of Benefits refers to rules for the order of payment of covered medical benefits when an individual is covered by two or more insurance plans. The primary plan pays first and a secondary plan many cover costs not paid by the primary plan.

Co-pays when imposed by a health benefit plan are always paid by the member when using a specific benefit, such as a $10 co-pay for office visits. Co-pays often do not count toward deductibles or maximum out-of-pocket expense limits.

Deductible is a dollar amount that a health plan member is liable to pay before the health plan pays for the cost of care. For example, the health plan member might be responsible for $250 of health care costs before the health plan picks up the cost of coverage. The type of costs that count toward the deductible are stated in the health plan.

Dependent Eligibility Audit is conducted for employer-sponsored health benefit plans to determine that those plan members covered as the spouse or dependents of the plan meet the plan's eligibility requirements. An audit will typically identify and remove former spouses no longer eligible for coverage after a divorce, adult children who exceed the age limit for dependent coverage, or others (e.g., grandchildren) who do not meet eligibility requirements.

Electronic Health Record refers to a computerized and electronically stored patient health record that provides a patient's medical history, drug allergies, current medications, and other information to help physicians provide beneficial and safe healthcare. Updated EHRs with real-time information would generally be available immediately to all physicians and health care providers a patient sees.

Eligibility is established by the terms of the health plan and in some cases may be governed by law as well.

Evidence-based Care (Best Medical Practices) refers to a decision-making protocol used by physicians and other health care providers, which is based on applying the best available evidence when treating patients. When physicians make evidence-based treatment decisions, they follow scientifically proven protocols, instead of their own conclusions.

First Dollar Coverage means the health plan will begin paying its share of a health service cost when that service rather than waiting until out-of-pocket expense limits are met. For example, a plan may opt to pay for preventive health care measures (e.g., annual exam, mammogram, colonoscopy, vaccines, etc.) without requiring the member to meet the deductible limits.

Flexible Spending Arrangements (FSAs) are federally tax-exempt medical spending accounts primarily funded by an employee through a "voluntary salary reduction agreement" (pre-tax withholding) with the employer. Employers establish the agreements and can also make contributions to the FSA. This is a "use-it-or-lose-it" plan meaning that the amount committed in a year must be used in that same year or the employee loses that money. The only exception is if the plan allows for a grace period not to exceed 2 ½ months for the employee to use funds left at the end of the calendar year. Health insurance premiums and long-term care coverage are not qualified medical expenditures eligible for reimbursement from an FSA. The maximum an employee commits to the FSA can be reimbursed before the amount is withheld from their salary. Reimbursements require submission of a statement from an independent third-party of the amount of the expense.

Health Care Provider refers to an individual professional, organization, or institution that delivers health care.

Health Information Technology is an umbrella term, which describes the technologies and components of a secure interoperable electronic system—like an intranet—that allows health information to be exchanged and managed in an efficient and effective manner. Health information technology includes *electronic prescribing* and *electronic health records*. Health information technology can prevent medical errors, increase administrative efficiencies, improve health care quality, and reduce health care costs.

Health Management Organizations (HMOs) are a type of managed care organization. Members receive health care through a network of hospitals, doctors, and other providers who are under contract to the HMO and provide care under the guidelines and restrictions of the HMO. An HMO may require a member to select a primary care physician to act as a gatekeeper for referrals. An HMO may not pay for care outside of the network unless it is pre-approved or deemed and emergency.

Health Reimbursement Arrangement (HRA) is funded entirely by the employer to reimburse individual employees for medical expenses. Employees receive federal tax exempt reimbursements for qualified medical expenditures up to a maximum dollar amount for the coverage year under the HRA. Unused amounts can be carried forward for future year reimbursements. HRAs can be offered in conjunction with other employee health benefits. Qualified medical expenses may include nonprescription medicines, health insurance premiums, long-term care coverage. Any distribution from an HRA to an employee for something other than a qualified medical expense is included in the employee's gross, taxable income for the year.

Health Risk Assessments are surveys used to identify opportunities to improve someone's health. The assessment might be scored in some fashion or be accompanied by recommendations on steps someone should take to improve their health. An assessment could also be followed up by contact from a "coach" who might guide someone on the next steps to take to better health.

Health Savings Account (HSA) is a federally tax exempt trust or custodial account to pay for or reimburse certain medical expenses for those enrolled in a high deductible health plan (HDHP). Individuals and employers can make contributions that are excluded from gross income. Earnings on the deposits and distributions for qualified medical expenses are also tax-free. Account balances at the end of the year rollover to the next year. For the 2009 tax year, an individual can contribute up to $3,000 and a family can contribute up to $5,950. Nonprescription medications and long-term care coverage may be qualified expenses, but health insurance premiums are not qualified expenses with limited exception. A distribution for nonqualified medical expenses is included in gross income for the year and may be subject to an additional 10% tax.

High Deductible Health Plans (HDHP) is a type of insurance that keep premium costs low by having the member assume a greater share of costs through high deductibles. An IRS qualified HDHP allows a participant to establish a tax-advantaged health savings account (HSA). The maximum out-of-pocket limits if $5,800 for the individual and $11,600 for a family. An HDHP could apply all services used to the deductible or establish "first dollar" services, such as preventive care. First dollar means the plan pays for those services before a deductible is met.

Incentives are typically monetary, though not often direct payments, and can be rewards, reduced premium shares, adjusted deductibles, reduced co-pays, or contributions to accounts (e.g., health savings accounts).

In- (Out-of-) Network refers to the providers affiliated with or under contract to a specific health plan (e.g., HMO, PPO). In-network providers have negotiated discounted reimbursement rates with the plan and those rates in turn influence the cost structure of the plan (i.e., premiums, co-pays, co-insurance, deductibles). Out-of-network providers have not negotiated discounted contracts for services with the plan. A member may need to get pre-approval before using an out-of-network provider and will certainly pay more out-of-pocket for going out-of-network.

Out-of-pocket expenses are the costs, separate from premiums, incurred by a member when health benefits are used and typically include co-pays and coinsurance. Health benefit plans often have an annual maximum out-of-pocket expense limit. When a member's expenses reach that limit, the plan typically assumes 100% of all costs above that limit. Co-pays may not count toward out-of-pocket expense limits. Limits usually apply to a single plan year, so when the next plan year starts members once again pay their share of benefit costs until the annual maximum is reached.

Preferred Provider Organization (PPOs) is a type of managed care organization that has contracts with a network of providers but does not require a member to have a primary care physician responsible for all referrals. Members are not restricted to using network providers; however, member costs for using out-of-network providers are typically higher, thereby, creating a financial incentive to stay in-network.

Premium is the monthly or annual cost paid for the health benefit plan.

Premium Share is the portion of the premium paid by the employer and employee when the health benefit plan is sponsored by the employer. The total amount paid is 100% of the premium cost, but the share assumed by the employer or employee can vary widely.

Preventive Care refers to health care interventions that stop disease or injury from occurring or detect the early stages of disease when treatment may be the most effective. Immunizations or vaccines are a classic example of preventive care as they have the potential to stop the vaccinated individual from developing an infectious disease. Pap smears and colonoscopies are examples of interventions that can detect abnormal cells that have the potential to progress to cancer cells, so treatment can commence before the cancer develops.

Primary Care is the term used for the provider who is the first point of consultation for care of patients.

Reinsurance protects an insurer against excessive aggregate losses in a plan or the high costs of individuals with catastrophic claims. The insurer purchasing reinsurance is called the *ceding company* as they are transferring or ceding risk to the reinsurer. The company selling reinsurance is called the *assuming company* as the reinsurer is assuming risk and agrees to reimburse the ceding company for losses covered by reinsurance.

Self Funded refers to a large group that is entirely responsible for paying the costs, and assuming the risks, of health care incurred by the members enrolled in its health plan. The group may contract with a third party administrator to manage plan enrollment and claim processing. A self-funded plan may or may not purchase reinsurance. A self-funded health plan may be less costly as the group does not incur the costs imposed by the insurer to assume the groups risk.

Third Party Administrator (TPA) processes claims and/or plan benefits on behalf of the self-funded employer or health plan. Services provided by a TPA can include claims administration, open enrollment, premium collection, eligibility audits, etc.

Tobacco Surcharges refer to an additional monthly surcharge added to the premiums paid by members who participate in unhealthy activities, such as smoking.

Value Based Insurance Design uses incentives to encourage members to use high value services (e.g., prescription drugs and prevention services), adopt healthy lifestyles (e.g., quit smoking or increase physical activity), or use high performance providers that adhere to evidence-based treatment guidelines. Application of the principles may be "non-targeted" meaning they apply to a service regardless of who uses that service, or "targeted" meaning they target participants in a specific program. Non-target application works when the service delivers high-value no matter who participates. Target application works best when the incentives remove barriers to services most likely to improves a participant's health, such as, reducing the cost of services diabetics need to improve their health.

Wellness Programs offer or promote a variety of activities, such as health fairs, health screenings, and health education programs designed to change and encourage healthier behaviors for participants. Prevention is the primary focus, as wellness activities try to highlight opportunities to adopt healthier behaviors to avert or delay the onset of health conditions that will require medical treatment or diminish overall health and the quality of life.

Pharmacy Benefits Terms

Brand Name Drugs are drugs which are trademarked by drug manufacturers and typically high priced.

Dose Optimization Program refers to a program to encourage the use of the most optimum dosage form or strength of a prescription. An example is to prescribe one 10 mg tablet of a drug once a day instead of one 5 mg tablet twice a day. This saves money on the cost of the drug and the drug copay, since many drugs cost the same irrespective of the strength of the medication and makes it easier for patients to stay on treatment regimes by reducing the number of times medication must be taken each day.

Electronic prescribing, or e-prescribing, refers to an electronically-based prescription system. At its simplest it refers to the electronic transmission of prescriptions from a physician to a pharmacy. At its most comprehensive it provides physicians with patient, drug, and health benefit plan information to help the physician choose the most effective and safest drug available. Additionally, e-prescribing can alert doctors and pharmacists to potentially deadly drug interactions or allergies.

Evidence-Based Prescribing refers to a decision making process which involves considering, and applying, the best available evidence when deciding which drugs to prescribe to a particular patient. For instance, published studies show that when treating a first time episode of schizophrenia, patients prescribed "second generation anti-psychotics" appear to have better outcomes than patients prescribed "first-generation drugs." A physician following evidence-based prescribing would look at the published studies and prescribe a second generation anti-psychotic to a patient presenting in his office with a first episode of schizophrenia.

Formulary refers to the entire list of prescription drugs covered by a particular drug benefit plan. Formularies are generally devised by committees composed of physicians and pharmacists who evaluate the clinical effectiveness, safety, and cost-effectiveness of prescription drugs.

Generic Drugs are drugs which contain the same active ingredient(s) as brand name drugs but are not trademarked and are typically less expensive.

Pharmacoeconomics refers to the scientific discipline that compares the value of one pharmaceutical drug or drug therapy to another. A pharmacoeconomic study evaluates the cost and therapeutic effectivness of different pharmaceutical products. There are several types of pharmacoeconomic evaluations such as cost-benefit analyses, cost-effectiveness analyses, and cost-utility analyses.

Pharmacy and Therapeutics Committee is a group of physicians and pharmacists who meet regularly to review new and existing medications and select medications to be included in a health plan's formulary based on safety, effectiveness, and cost-effectiveness.

Pharmacy Benefit Manager (PBM) refers to a business that acts like a "middle-man" between drug manufacturers, doctors, pharmacists, employers, i.e. the health benefit plan sponsors, and covered employees. PBMs negotiate pricing with drug manufacturers, develop and manage drug formularies, process payments to pharmacies, adjudicate pharmacy claims for plan sponsors, and assist consumers. Most health insurance plans provide prescriptions under the PBM business model. PBMs are generally better able to negotiate lower drug prices and receive bigger rebates for expensive brand name drugs.

Pill Splitting refers to prescribing higher strength tablets, which cost the same as a lower strength tablet, and then breaking the tablets in half or quarter doses as a way to lower drug costs.

Preferred Drug List (PDL) is a list of drugs from within a formulary that cost less and that are "automatically covered." Drugs which are not on the list may still be covered; however, they require prior authorization before they may be dispensed. Patients are encouraged to use a preferred drug because it is easier and less costly to obtain. Alternatively, it is harder and more expensive to get non-preferred drugs.

Pharmacy Benefits Terms (cont.)

Prescription Drug Carve Out refers to removing prescription drug benefits from HMOs, which allows a plan sponsor, or employer, to pool all its covered employees into one group for the purpose of purchasing prescription drugs.

Prescription Drug Claims Processor (PDCP) refers to a business entity that acts like a PBM but does not negotiate with drug manufacturers or develop formularies. These activities are performed by the employer, or plan sponsor, while the PDCP does claims processing, adjudicating, and consumer assistance.

Prior Authorization refers to a process where patients must receive approval from the insurance company before a non-preferred prescription drug can be dispensed.

Step Therapy is a program intended to control the costs of prescription drugs by categorizin drugs as first, second, or third line drugs. First line drugs are automatically covered, while second and third line drugs require pre-approval from the insurance company before they can be dispensed. Generic drugs are usually in the first step, while brand-name drugs are usually in the second step.

Tiered Pharmacy Benefit Design refers to categorizing drugs in tiers and charging higher copays for higher tier drugs. Generic drugs are typically in tier 1, brand name drugs in tier 2, and non-preferred drugs are in tier 3.

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